OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM OCCUPATIONAL/MEDICAL QUESTIONNAIRE

(See Form ARS-182A/B for Privacy Act Notification)

	DEMOGRAPHIC INF	FORMATIO	N			
LAST NAME	FIRST NAME			MIDDLE NAME		
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yyyy)			SEX M	IALE	FEMALE
RACE BLACK/NOT HISPANIC ORIGIN WHITE/NOT HISPANIC ORIGIN HISPANIC ASIAN/PACIFIC ISLANDER	AMERICAN INDIAN/ ALASKAN NATIVE OTHER (specify):	MAR	GLE/NEVEI	R MARRIED NG TOGETHER		DIVORCED WIDOWED
FMPI OYFF'S	MAILING ADDRESS (Where	e confidenti	al mail ca	n he delivered)		
STREET	MAILING ABBREGO (WIEN	APARTMENT				
		OIME	211 0052			
	EMPLOYEE'S PH	HYSICIAN				
LAST NAME STREET ADDRESS		OFFICE TELEI	PHONE (Inclu	ıde Area Code)		
STREET ADDRESS		SOITE NO.				
CITY		STATE	ZIP CODE			
	EMPLOYEE'S CUR	RENT JOE	3			
LOCATION (City)	<u> </u>	NICE OF THE PROPERTY OF THE PR		STATE	ZIP CODE	
REGULAR WORKPLACE (Building and Room No.)				•	GS SERIES	
JOB TITLE					YEARS IN PR	RESENT JOB
Have you ever been a resident outside the l			Yes			
If yes, please list the location(s) and o	date(s).			M	FROM IONTH/YEAR	TO MONTH/YEAR
1.						
2.						
3. 4.						
5.						
6.						

SOCIAL	SECURITY NO	١

EMPLOYMENT HISTORY

Start with the job you held before this one, and list	all the jobs yo	u ever had.	Include military service and any part-time jobs.
COMPANY NAME OR TYPE OF BUSINESS	FROM MONTH/YEAR	TO MONTH/YEAR	JOB TITLE OR DESCRIPTION
	1	1	Í

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				REC	REATION (Pleas	NAL HIST	ORY								
Do you now or have you in the past, do	ne any of	the fo	llow	ing as a hob	by or	Do you no	w or ha	ve :	you ir	n the past,	come into con	tact with	n any of	the foll	lowing
during your spare time?				PRE-	CUR-	during your spare time?					PRE		CUR-		
Auto mochania wark		<u> </u>	10	VIOUSLY	RENTLY	Acido				NO	VIOUS	LY	RENTLY		
Auto mechanic work Auto body work						Acids									
Been exposed to rubber cement for						Bonding ag		ind	ustria	il glues					
extended periods of time						Cleaning fluids									
Carpentry						Fertilizers									
Ceramics						Gasoline o	r other	peti	oleur	n products					
Etching/metal work/jewelry/metal sculptu	ıre					Herbicides	or wee	d ki	llers						
Furniture refinishing						Insecticide	s/pestic	ide	s						
House painting						Insulation	material								
Lawn/Garden maintenance or farming						Lacquer, v	arnish c	or e	name	l paints					
Make your own cartridges/salvage spent cartridges						Leather dy									
Make your own fishing sinkers						Paint thinn	ers and	rei	move	rs					
Oil painting						Soldering a	agents								
Pottery						Solvents/d	egrease	ers							
Recreational hunting/shooting						Wood stair	าร								
In your work are you now or have you be	een expos	sed to	any	of the followi	ing agents?							ı			
	PRE-		1				PRE-	1						PRE-	1
	SENT	PAST	_				SENT	P	AST					SENT	
Inorganic flourides			-	Excessive r						Asbest					
Lead Benzene			┢	Nitrogen oxi Crystalline						Pesticio	ect or known carcinogens				-
Coke oven emissions			\vdash	Nitric acid	Silica						ria or viruses				
Inorganic arsenic			┢	Ammonia							ate animals				
Methylene chloride			t	Beryllium							ting tools				
Vinyl chloride				Phosgene							diation (lonizing)				
Toluene diisocyanate			T	Allyl chloride	e					Radiati	Radiation (Non-Ionizing)				
Please make a list of those substances that you handle in your work. Star (*) those that particularly concern you from a health standpoint.															
Indicate any symptoms that you have ex SYMPTOM:	xperience	d that	mig	ht be due to	exposure at	work and indi	cate the	e su	spec	ted cause.	CAUSE:				
Have you experienced any job related if IF YES, GIVE DETAILS:	llnesses o	or injur	ies s	since being e	mployed by	the USDA?	□ No)		Yes	MONTH AND Y	EAR:			

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	SMOKING HISTORY	LIFE-STYLE HISTORY				
CIGARETTES: Have you No Yes ("No" means never smoked, or smoked less than 20 packs of cigarettes or 12 ozs. of tobacco in life-time, or less than 1 cigarette a day for one year.)	e. Do, or did you inhale the cigarette smoke? If yes, please answer the following questions.) A	b. Have you stopped drinking regularly? No Yes If yes, how many years ago did you stop? c. How much do (did) you drink on an average day or in an average week?				
PIPES: Have you ever s No Yes ("No" means never smoked, or smoked no more than 12 ozs. of pipe tobacco in your life-time.)	imoked a pipe regularly? (If yes, please answer the following questions.) a. How old were you when you started smoking pipes regularly? b. Do you still smoke pipes? If yes, how many ounces of pipe tobacco do you now smoke per week? C. If you have stopped smoking	than 7 drinks per week. 1 to 2 drinks per day, or 7 to 17 drinks per week. 3 to 4 drinks per day, or 18 to 31 drinks per week				
CIGARS: Have you ever No Yes ("No" means never smoked, or smoked no more than 1 cigar a week for 1 entire year.)	a pipe, how old were you when you stopped? d. On the average, of the entire time you have smoked, how many ounces of tobacco did you smoke per day? e. Do, or did you inhale the pipe smoke? I smoked cigars regularly? (If yes, please answer the following questions.) a. How old were you when you started smoking cigars regularly? b. Do you still smoke cigars? If yes, how many cigars do you now smoke per day? Years Years Cigars/day	c. Describe the kind of exercise you get:				
TOBACCO CHEWING: I	c. If you have stopped smoking cigars, how old were you when you stopped? d. On the average, of the entire time you have smoked cigars, how many cigars did you smoke per day? e. Do, or did you inhale the cigar smoke? Have you ever chewed tobacco regularly? (If yes, please answer the following questions.) a. How old were you when you started chewing tobacco regularly? b. Do you still chew tobacco? No Yes	Meat Sodium or Salt Sugar Foods high in cholesterol Other (describe):				
SNUFF: Have you ever	c. If you have stopped chewing tobacco, how old were you when you stopped? Years	c. How many years have you been restricting your diet? d. Why are you restricting your diet? Religious Medical reasons Other (describe):				

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MEDICAL HISTORY

CARDIOVASCULAR: Have you ever had or do you now have any of the follow		following	DIGESTIVE SYSTEM: Have you ever had or do you now	have an	following		
illnesses or problems with your heart or blood vessels?	NO	YES PAST	YES CURRENT	illnesses or problems with your digestive system?	YES PAST	YES CURRENT	
Heart Attack				Blood in stool			
Angina Pectoris				Stomach or Duodenal Ulcer			
Heart Murmur				Appendicitis			
Enlarged Heart				Nervous stomach			
Stroke				Colitis			
High Blood Pressure				Frequent constipation			
Other problems with blood pressure				Frequent diarrhea			
Episodes of chest pains, tightness, discomfort				Frequent indigestion			
Rheumatic Heart Disease				Stomach pain			
Arteriosclerosis				Hiatal hernia or rupture			
Varicose Veins				Diverticulitis			
Other (specify):				Hemorrhoids or piles			
(-p/)				Other (specify):			
Have you ever had heart surgery? (If yes,				Galer (Gposny).			
,		1					
						1	
RESPIRATORY ILLNESS/CONDITIONS: Have you had o	r do voi	u now h	ave any	system?			
of the following illnesses or problems with your lungs?	uo yo	YES	YES	(If yes, describe):			
	NO	PAST	CURRENT				
Frequent Colds							
Coughed up Blood				LIVER AND SPLEEN: Have you ever or do you now have		of the fo	llowing
Chronic Cough				illnesses or problems with your liver, spleen, or gallbladde	r?	YES	YES
Lung or Breathing difficulties or Shortness of Breath					NO	PAST	CURRENT
Asthma				Cirrhosis of the liver			
Emphysema				Hepatitis			
Pneumonia				Jaundice			
Tuberculosis				Gallbladder disease			
Bronchitis				Gallbladder stones			
Pleurisy				Injury to your spleen			
Other (specify):				Other (specify):			
(-p/)		1				•	
Have you ever had surgery on your lungs?							
(If ves. describe):		1				1	
				Have you ever had surgery on your liver or spleen? (If yes, describe):			
				(11 you, dodo/150).			
Have you ever had or do you now have any of the follow	owing p	roblems	with your				
mouth, nose or throat?	NO	YES	YES			_	
	NO	PAST	CURRENT	KIDNEYS/URINARY TRACT: Have you ever had or do y following illnesses or problems with your kidneys or urina			ny of the
Nasal passages frequently irritated				following limesses of problems with your kidneys of drina	ly tract?	YES	YES
Nose Bleeds often		1			NO	PAST	CURRENT
Throat is often irritated		1		Blood in urine			
Voice is hoarse when you do not have a cold				Pain or burning when urinating			
Mouth/Gums frequently have sores/ulcers				Kidney disease			
Gums shrinking, irritated or bleeding				Kidney infection			
Other (specify):				Kidney stones			
				Nephritis (Bright's Disease)			
ENDOCRINE: Have you ever had or do you now have an	ny of the	e follow	ing	Bladder Infection			
illnesses or conditions?		YES	YES				
	NO	PAST	CURRENT	Prostate gland enlargement/infection (Males only)			
Hypoglycemia		1		Tumor in urinary tract	 		
Diabetes				Other (specify):		ı	<u> </u>
Goiter		1					
Thyroid disease or disorder		1					
Swollen glands or nodes		1		Have you ever had surgery on your kidneys or urinary			
Pancreatitis				tract? (If yes, describe):			
Other gland problems (specify):							

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OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM **MEDICAL HISTORY** (Continued)

REPRODUCTIVE HISTORY (please answer all four questions):				BONES AND JOINTS: Have you ever had or do you no	ow have	any of	the
a. Have you or your partner ever had a problem conceiving a ch	ild?	Yes	No	following problems with your bones or joints?		YES	YES
Present Previo	u			Arthritis or Rheumatism	NO	PAST	CURRENT
If yes, Self Partner Partner	r			Gout	+		
b. Have you or your partner consulted a physician for a fertility	or othe	r reproc	ductive	Joint pains	+		
problem? Yes No				Bone infections	+		
If yes, specify who consulted the physician:				Bursitis or tendonitis	+		
				Backache, back trouble, sciatica	+		
Self Partner Self and Partner				Foot trouble, flat feet or fallen arches	+		
If yes, specify the diagnosis:				·	+		
				"Trick", "locked", or "loose" knee	+	 	
				Back injury or herniated disk	+	 	
c. Have you or your partner ever conceived a child resulting in a	a misca	rriage, s	still birth	Painful or trick shoulder	+		
or Yes No				Swollen or painful joints Other problems with your bones or joints (If yes,	+		
If yes, Miscarriage Still Birth	Defor			specify):			
If yes, Miscarriage Still Birth	Offsp	ring		, ,			
If outcome was a deformed offspring, what was the deformity	y?						
				Have you ever had surgery (including setting of broker	bones)	on any	of your
Was this outcome a result of a pregnancy of yours with:				bones or joints? (If yes, describe):			
Present Partner A Prior Partner							•
Present Partiel A Prior Partiel							
d. Did the timing of any abnormal pregnancy outcome coincide v	vith you	r prese	nt	SKIN: Have you ever had or do you now have any of	the follo	wing sk	in
employment? Yes No				·· -		YES	YES
List dates of occurrences:					NO	PAST	CURRENT
northant				Hives	<u> </u>		
partner?				Eczema	<u> </u>		
NERVOUS SYSTEM: Have you ever had or do you now have an	y of the	followi	ng	Psoriasis	<u> </u>		
illnesses or problems with your nervous system?	NO	YES PAST	YES CURRENT	Rash on elbows, knees, or scalp	<u> </u>		
Frequent headaches	NO	FASI	CONNEINT	Rash other than on elbows, knees, or scalp			
Migraine headaches				Severe stubborn dandruff			
Epilepsy, convulsions, seizures				Small itching blisters on the sides of your fingers or			
Nervous breakdown				palms	┼		
Depression/Excessive worry				Excessive sweating on palms, soles, or armpits	┼		
				Sores that do not heal	 		
Loss of memory (amnesia)				Moles that bleed or get larger	 		
Nervousness				Change in color of skin (other than suntan)	 		
Tremor of the hands or head				New growth on skin	_		
Palsey or tremors				Other (If yes, describe):	Ь		
Severe head injury							
Neuritis							
Paralysis of any type				ALLERGIES: Have you ever had or do you now have a	ny aller	gies?	
Other problems (specify):					NO	YES PAST	YES CURRENT
				Medications (If yes, please list):	INO	PASI	CURRENT
							<u> </u>
BLOOD: Have you ever had or do you now have any of the foll	owina I	olood di	seases or				
problems?	9 1	YES	YES				
	NO	PAST	CURRENT		NO	YES PAST	YES CURRENT
Anemia				Food			
Low hemoglobin				Soaps or detergents			
Bleeding disorder				Chromium			
Leukemia				Nickel	1		
Sickle cell disease or trait			<u> </u>	Rubber	†		
Phlebitis				Epoxy resins	 	 	
Other problems (specify):				Plants (e.g., poison ivy, etc.)	+		
•				Pollen	+	 	
				Insect scales	+	 	
				Bee stings	+	├──	
		1			<u> </u>	<u> </u>	<u> </u>
Have you ever had a blood transfusion?			1	(NOTE: This section continues at top of	of next	nage.)	

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MEDICAL HISTORY (Continued)

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ALLERGIES (Continued)	NO	YES PAST	YES CURRENT			ever been diagnosed with cancer? (If yes, list the year and type of	of diagno	neie)	
House dust				∐ No	Year	Specific Tissue Diagnosis (If availal		7515./	
Animal dander, feathers, or fur				Type Skin	Teal	Specific Tissue Diagnosis (ii availat	ne)		
Sunlight or cold				Colon					
Other (If yes, please list):				Breast					
				Lung					
				Prostate					
				Cervical					
Do you react with:					es, specify	type and describe tissue diagnosis	and yea	r):	
Rash									
Hives				INFECTIOU	S/CHILD	HOOD DISEASES: Have you had or	do you	now ha	ve: YES
Hay fever symptoms							NO	PAST	CURRENT
Breathing difficulty				Mononucle	eosis				
Other (If yes, describe):				Meningitis					
				Malaria					
				Polio					
				Rheumati	c fever				
EARS: Have you ever had or do you now have any of the	ne follov	ving pro	blems	Scarlet fe	ver				
with your ears or your hearing?	No	YES	YES	Mumps					
Difficulty in hearing	INC	PAST	CURRENT	Measles					
Difficulty in hearing Tinnitus (ringing/buzzing) in right ear				Chicken p					
in left ear				German m	neasles				
Nasal allergy				Tonsillitis					
Vertigo (dizziness)				Gonorrhea	1				
Perforation of the ear drum				Syphilis					
Ear drainage (caused by infection or injury)				brothers, sis	sters, aun	lave any of your blood relatives (par ts, uncles or children) had any of the	ents, gra Itoliowin	andpare la veo	
High fever						YES CURRENT			
Infection of inner ear				Anemia					
Hearing loss by blood relatives (such as				Alcoholism	n				
grandparents, parents, aunts, uncles, brothers, or				Allergies					
sisters) before they reached the age of 60				Arthritis					
Other problems with your ears (If yes, describe):				Asthma					
				Bleeding d	disorders ((free bleeder)			
				Breast car	ncer				
EYES: Have you ever nad or do you now have any of tr	o tollov	una pro	niome with	Cervical c	ancer				
your eyes or your vision?	le ioliov	-		Chronic br	ronchitis				
, , ,	NO	YES PAST	YES CURRENT	Congenita	l malform	ations (birth defect)			
Glaucoma				Diabetes ((sugar)				
Cataracts				Digestive	or bowel	disease			
Conjunctivitis (pink eye)				Eczema					
Blurring of eyesight				Emphysei	ma				
Vision getting worse				Epilepsy					
Seeing double				Glaucoma	1				
Seeing halos around lights				Gout					
Pain in the eyeball				Hay fever					
Eyes are often bloodshot				Heart atta					
Right eye Injured (e.g., Solatolied, Dullied, Odt,				Heart dise					
Left eye				High blood					
Right eye Foreign object accidentally embedded in				Kidney or		isease			
Left eye the eye				Kidney sto		dianaa			
Other problems with your eyes (If yes, describe):				Liver or ga		uisease			
, , , , , , , , , , , , , , , , , , , ,	•	•		Lung cand					
				Mental illn					
				Mental reta		00000			
Do you wear glasses?				Nervous s	system di	>Ed>E			
Do you wear glasses? Do you wear contact lenses?				Psoriasis	(NOTE:	This section continues at top of	novt =	200)	

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MEDICAL HISTORY (Continued)

			1	OTT (Continued)
FAMILY HISTORY (Continued)	NO	YES PAST	YES CURRENT	IMMUNIZATIONS, VACCINES, ANTITOXINS: If you have received any of the following, check the appropriate box(es) and give the approximate dates, if known.
Sickle cell disease or trait				Date
Stroke				<u>(mm/dd/yyyy)</u>
Thyroid disease				Tetanus
Tuberculosis (T.B.)				Poliomelitis
Ulcer (stomach, duodenal, peptic)				Influenza
Other cancers or leukemia			<u>L</u>	Typhoid
Is your mother still living?	☐ No	,	Yes	片 ¨
If not, please give age at death:		Year	s	Diptheria
and cause of death:		-		Rabies
				Rubella (German measles)
Is your father still living?	Пис		Yes	Measles (Rubeola or red measles)
If not, please give age at death:		Year		BCG
and cause of death:				Yellow Fever
				Smallpox
Are you aware of any disease or illnesses that	□ No		Yes	RhoGAM (Rh immune globulin)
run in your family? (If yes, please list below):	INC	' [162	
				Immune serum globulin for hepatitis
				Others (please list):
				Mantoux, patch test, or other skin
				test for tuberculosis
				Results: Positive Negative ————
				LUCTORY OF HOORITALIZATION III
IFDICATIONS: However taken only of the following to	a dia atia a		last	HISTORY OF HOSPITALIZATION: Have you ever been hospitalized? No Yes (If yes, list reason(s) and date(s) of hospitalization.)
EDICATIONS: Have you taken any of the following m	edications	YES	YES	No Yes (If yes, list reason(s) and date(s) of nospitalization.)
	NO	PAST	CURRENT	
Antacids				
Antibiotics (e.g., penicillin, ampicillin, tetracycline)				
Antihistamines				
Aspirin				
Benzedrine / Dexedrine				
Birth control pills				
Blood thinners (anti-coagulants)				
Codeine				
Cortisone or other steroids				
Diet pills				
Digitalis or other heart pills				Do you have any problems you would like to discuss with the doctor?
Diuretic or water pills				No Yes (If yes, please list them):
Hormones				
Insulin or oral anti-diabetic drugs				
Iron pills				
Laxatives				
Morphine		ļ		
Nitroglycerine			-	
Pain killers (aspirin, empirin, anacin, bufferin, etc.)			-	
Pep pills or Mood elevators	_	<u> </u>		
Pills to lower your blood pressure	+		1	
Sleeping pills	+		1	
Sulfa preparations			-	
Thyroid medication			-	
Tranquilizers, sedatives, or nerve pills	1		1	
Vitamina				SIGNATURE AND DATE COMPLETED
Vitamins Others				SIGNATURE AND DATE COMPLETED (Mo.) (Day) (Yr.)